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Trying to make sense of the chaos: Clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder'

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Abstract

Background: Evidence of negative perceptions of clients with 'borderline personality disorder' (BPD) in mental health professionals has been well documented. However, few researchers have focused upon perspectives of clinical psychologists on this client group. The aim of the present research was to explore clinical psychologists' experiences and perceptions of clients with BPD.

Method: Sixteen female clinical psychologists (including trainees and qualified staff) participated in focus groups, twelve of whom had direct clinical experience with this client group. All four groups were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (Smith, 1996).

Results: The following eight superordinate themes emerged from the analysis: 'negative perceptions of the client'; 'undesirable feelings in the psychologist'; 'positive perceptions of the client'; 'desirable feelings in the psychologist'; 'awareness of negativity'; 'trying to make sense of the chaos'; 'working in contrast to the system'; and 'improving our role'.

Discussion: Implications include concerns regarding negativity, yet also the suggestion of hope and optimism in working with this client group.

Key words: borderline personality disorder, staff perceptions, clinical psychologists, therapeutic relationship, qualitative methods

Word count: 7805

Introduction

There is growing promising evidence of effective interventions for clients with borderline personality disorder (BPD) (e.g. Davidson *et al*, 2006; Giesen-Bloo *et al*, 2006; Linehan *et al*, 1993) and evidence that clients with BPD value their contact with mental health services (e.g. Fallon, 2003). Despite this, there is ample evidence from the research to date of negative perceptions of clients with BPD amongst mental health professionals (e.g. Fraser & Gallop, 1993; Gallop *et al.*, 1989; Markham & Trower, 2003; Nehls, 2000; Servais & Saunders, 2007).

Studies have shown that nursing staff make more negative attributions about and rate their experiences of working with clients with BPD more negatively than those with labels of depression or schizophrenia (Markham & Trower, 2003; Markham, 2003). Moreover, Markham (2003) suggests that while such negative attitudes towards clients with schizophrenia may reduce with knowledge, training, or other possible group differences, those towards clients with BPD may not. Similar negative perceptions of clients with BPD have been found in other professions. For example, Lewis & Appleby (1988) found that in response to a vignette, psychiatrists regarded clients with BPD as more 'difficult' and less deserving of care than those without this diagnosis, and viewed them as 'manipulative' and 'annoying'. Similar findings have been reported in multidisciplinary teams and using a variety of methods (Walter *et al.*, 2003).

Brody & Farber (1996) found that in response to a vignette, clinical psychologists' (CPs') ratings of anger and irritation were higher for clients with BPD than for people

with depression or schizophrenia labels, and their ratings of liking, empathy, and nurturance were lower for clients with BPD compared to those with the other labels. In this study, again professional experience did not have an overall notable effect on responses to the vignettes. In another vignette study investigating CPs' perceptions of clients with 'mental illness', Servais & Saunders (2007) found that clients with BPD were rated as the least safe, the least worthy, and the least desirable compared to clients with schizophrenia or moderate depression.

The Role of Staff Perceptions in Care-Giving

For clients with BPD, the therapeutic relationship is critical. One way of understanding this is through attachment theory (see Bowlby, 1988). It has been argued that in clients with BPD, often as a consequence of early traumatic childhood experiences, the attachment system has become oversensitive to separation and loss (Sable, 1997). From this perspective, one purpose of the therapeutic relationship is to provide a secure base and to modulate anxiety, where secure attachment will be facilitated through accurate, sensitive, and appropriately balanced responding to distress (Adshead, 1998). In line with this view, a review of the evidence for effectiveness of psychotherapeutic treatments for personality disorders suggests that the encouragement of a powerful attachment relationship between client and therapist is a common feature of treatments shown to be effective (Bateman & Fonagy, 2000). Similarly, evidence suggests that psychotherapy which focuses on the affect-laden themes within the therapeutic relationship is predictive of significant improvement across a range of domains for clients with BPD (Clarkin et al., 2007).

Yet there are several ways in which staff perceptions may affect the therapeutic relationship. When faced with stress, health care professionals may develop maladaptive interpersonal strategies with clients, which can take the form of dismissing the client's distress (Adshead, 1998). When challenging behaviour is perceived as volitional and intractable, it can create a sense of hopelessness about the effectiveness of intervention (Nehls, 1998). Servais & Saunders (2007) emphasise that such negative perceptions may not only prevent the clinician from being able to display empathy and genuine concern for clients, but also discourage the efforts of clients to make progress in therapy. Furthermore, dismissing a client's needs can lead to anger, and a desire to reject clients perceived as 'troublesome' (Adshead, 1998). Therapists may then feel overwhelmed by such emotions, and may act them out in an overtly unhelpful manner, or more frequently, in a covert form, such as rigidly enforcing a contract (Adshead, 1998). Undoubtedly, these factors could all compromise the therapeutic relationship.

In contrast to the dangers of dismissing clients' needs, Markham & Trower (2003) highlight the cautions of staff making attributions that they are responsible for solving their clients' problems, which can lead to pressure and burnout. Over-involved therapists may also find it difficult to keep within the boundaries of the therapeutic relationship, or to allow their clients to improve and regain independence (Adshead, 1998).

Indeed, negative perceptions may influence treatment decisions and weaken the effectiveness of treatment (see Servais & Saunders, 2007). Furthermore, the stigma of BPD may be perpetuated by mental health professionals with negative perceptions

failing to challenge misconceptions of BPD, and modelling inappropriate behaviour (Servais & Saunders, 2007).

Study Rationale

Research on staff perceptions of clients with BPD has highlighted the prevalence of negative views (e.g. Lewis & Appleby, 1988; Markham & Trower, 2003; Nehls, 2000). This has included some investigation of perceptions of clients with BPD amongst CPs (Brody & Farber, 1996; Servais & Saunders, 2007). Further research considering CPs' perceptions as a therapist group would add to the existing evidence base, and using a qualitative methodology to explore their 'real-life' experiences of clients with BPD would extend the range of methodologies used in the wider literature.

The aim of the present study was to explore CPs' experiences and perceptions of working with clients with BPD. It was anticipated that using a qualitative approach to explore this would reveal how CPs have experienced clients with BPD, how they feel about working with them, and how they perceive their role in the area.

A secondary aim was to tentatively note any differences in the experiences and perceptions of CPs at different stages in their careers.

Method

The design was based on the principles of interpretative phenomenological analysis (IPA) (Smith, 1996) and the focus group method.

Sample

Purposive sampling was used, meaning that the aim of recruitment was to sample CPs with a range of different levels of experience in working with people with BPD. All trainee CPs and qualified CPs from the Adult Clinical Psychology Department (those working within primary care and mental health services) within one Health Board area within NHS Scotland were identified and approached by letter. This area incorporates a mix of urban and rural communities. The invitational letter was sent to 23 potential participants. Within three days the researcher contacted them to ask if they were interested in participating. All potential participants who were either spoken to or replied by email said they were interested in participating. This was a total of 20 CPs (a 87 per cent response rate). However, four of these interested participants were not available to participate at the times that suited the majority. Thus, in the end, 16 participants (70 per cent of the total number of potential participants approached), twelve of whom had direct clinical experience with this client group, were arranged into four separate focus groups.

The sample comprised of nine trainee CPs and seven fully qualified CPs. The groups were ‘naturally occurring’, meaning that participants were colleagues who already knew each other. Trainees were organised into separate focus groups from qualified

CPs. Each participant took part in one of the four focus groups, which each met on only one occasion. The trainee groups comprised of one group of five and one group of four. The qualified CPs' groups comprised of one group of three newly qualified CPs and one group of four more experienced CPs. All participants were female. Stages in participants' careers ranged from the first year in training to 32 years post qualification.

In the UK, trainee CPs undertake a professional doctorate level training, comprised of supervised clinical practice, teaching and academic work, and a major research thesis. The standard length of training in the UK is three years. Most programmes teach a pluralistic approach, introducing trainees to psychodynamic, cognitive, behavioural, systemic and interpersonal orientations to therapy. Trainees early in training would not be expected to have had significant amounts of contact with clients with BPD. Late stage and newly qualified staff would normally have some experience and staff qualified for three or more years would be likely to have extensive experience of the client group.

Data Collection

All focus group sessions were held during February 2007. They were conducted by the first author, who was known to the participants due to being a trainee CP in the department at the time. The groups took place in a private meeting room in the clinical psychology department. The mean duration of the focus groups was approximately 80 minutes.

A semi-structured interview schedule was used (see Appendix I). It was constructed as a guide only, and was based on recommendations for constructing questions suitable for focus groups (see Krueger, 1994) and IPA (e.g. Smith & Osborn, 2003), with one question based on that used by Nehls (2000). The schedule incorporated a logical flow of questions, which were open enough to allow a variety of viewpoints to be expressed, and issues to spontaneously emerge.

Audio recordings of the focus groups were transcribed verbatim by the researcher, with corresponding non-verbal observations from field-notes amalgamated into the transcriptions throughout.

Data analysis

IPA (Smith, 1996) was the method of analysis chosen, as it attempts to study participants' experience of an object or event from his or her perspective, fitting with the current aim of studying participants' personal perceptions of clients with BPD.

IPA is a form of phenomenology which accepts the impossibility of gaining access to participants' life worlds (Willig, 2001). It is phenomenological, as it attempts to study the participants' experience of an object or event from his or her perspective, rather than attempting to produce an objective account of the object or event itself. Yet, it is interpretative, in that it recognises the necessary implications of the researcher's own view of the world, and the nature of the interaction between the researcher and participant, on this exploration. It is a distinctively psychological research method, which aims to gain insight into individual participants'

psychological worlds, and is concerned with the nature or essence of phenomena, rather than what accounts for such phenomena (Willig, 2001).

Process of analysis

The contributions of individual participants were separately analysed within the context of the group discussion as a whole, allowing the accounts of each participant to be retained, while interactions between participants were analysed as part of the group dynamic.

To conduct the IPA analysis of individual narratives, the researcher followed the step-by-step approach outlined by Smith & Osborn (2003). In this way, the first participant's account was read several times, in order to become as familiar with it as possible. While reading it, the left margin was used to summarise or paraphrase, comment on the use of language, note anything of interest, and make associations and preliminary interpretations about what the participant said. The whole of the first account was approached in this way, and then returning to the start of the account, the right hand margin was used to note any emerging themes. Terms were used to name the themes which were at a high enough level of abstraction to enable theoretical links across and within participant accounts to be made, yet were also grounded in what was actually said in the transcript. Some themes clustered together due to sharing references or meanings, and others appeared to be superordinate themes (i.e. themes which captured the essence of a cluster of themes).

Next, the list of emergent themes from the first participant's narrative were coded, and connections between them were looked for. A clearly structured table of the superordinate themes and their corresponding sub-themes was compiled. During this process, some themes were abandoned, due to a lack of rich evidence in the transcript. The themes from the first case were then used to help orient the coding of the other cases. In this process, new themes were coded as well as repeated ones, to ensure that similarities and differences between participants' accounts were recognised. The method for interpreting an account described above was conducted with each case. In keeping with the cyclical process, any new themes were checked against earlier accounts, to determine whether such themes were actually new themes, or merely new manifestations of earlier themes. In addition, the earlier accounts were checked to ensure prior manifestations of the new themes had not been ignored. A progressively integrated list of themes was developed, which was complete after the analysis of the sixteenth participant. This list was displayed in final clearly structured tables regarding each participant.

Following this, as based on recommendations by Kitzinger (1995), special categories were coded to take account of group factors, such as group silence, nods, or laughter. Such group dynamics were used to add emphasis to related themes in the analysis. For example, group nodding or laughter taking place while discussion centred around a certain theme was considered to add strength to the representation of that particular theme within that particular group. On the other hand, group silence was often interpreted as an attempt of the group to censor itself.

Validity and Quality

Using a qualitative methodology involves drawing on methods of assessing the quality of the research. To this end, criteria developed by Yardley (2000) were followed. These cover the three broad dimensions of 'sensitivity to context' (e.g. showing an awareness of the background literature), 'commitment, rigour, transparency and coherence' (e.g. personally transcribing the focus groups to allow immersion in the data), and 'impact and importance' (e.g. anticipating that the focus groups would not only explore CPs' experiences and perceptions of this client group, which itself would be likely to lead to implications for practice, but also serve to create new solutions in this area).

Results

Background information

Four of the trainees reported having no experience with clients with BPD. Interestingly however, as the discussion in the focus groups progressed, they began to wonder if they had indeed, worked with clients who may have met criteria for BPD, or presented with some BPD traits. As expected, within each group, it appeared that participants in later years of their training, or who were qualified for longer, reported having more experience in the area of BPD than those in their earlier years of training, or those qualified for a shorter time.

Themes

Eight superordinate themes emerged from the analysis. Figure 1 illustrates these, along with their corresponding sub-themes. Each superordinate theme will be explored in turn and the main sub-themes outlined.

Insert Figure 1 here

Negative Perceptions of the Client

All participants' narratives included manifestations of the theme of '**different, odd**', in that clients with BPD were viewed as having something markedly different about them from the other clients they had worked with:

> 4.2: …I can certainly think of a few people that I've worked with, and I think they tend to stick out in your mind, you know, they kind of stick out in a way.

Throughout, the use of language highlighted this view. Note in the following excerpt, for example, the emphasis on the word 'they; stresses how different the participant perceives the behaviour of clients with BPD compared to that of other clients:

> 3.3: …when they miss appointments they really are communicating something

Several participants conveyed clients with BPD as being different in an 'odd' sense:

> 2.1: I just thought of somebody looking really kind of manic [laughs] and dishevelled and hair everywhere, [laughs] just a picture that came into my head and I don't know, that was probably just my mind but just somebody really like, well somebody with a long skirt and big mad hair and…..

The following group joke illustrates the notion of 'us and them' particularly well, and could imply that the participants would prefer to distance themselves from their own vulnerability to having a personality disorder (see Servais & Saunders (2007) for further explanation of the 'disidentification' process):

1.3: I'm sure I read somewhere that 20 per cent of the population have some form of personality disorder so –
[All laugh]
1.5: That's worrying…It' one of us! [laughs]
[All laugh]
1.2: Well not that it was you [makes eye contact with 1.5] [All laugh] but it might be someone in this room [laughs]
[All laugh]
1.1: Well it's definitely, if it's 20 per cent it's definitely one of us, might be even two! [laughs]
[All laugh]

References to clients with BPD being different emerged in the context of rich narratives on 'undesirable feelings in the psychologist' (see below) and the tone used in such discussions tended to be negative, hence the inclusion of this sub-theme under 'negative perceptions of the client'. However, it should be noted that a positive side to the perceived difference also emerged in the context of a sense of interest in this particular client group (see 'desirable feelings in the psychologist).

A sense of clients with BPD deliberately making the psychologists feel certain ways, or being **controlling**, was prevalent in many participants' narratives across all focus groups:

1.1: I think it's even sometimes one step more than just the neediness but also kind of turning into blackmail [pause] you know, if that doesn't fit then this and this is going to happen to me, which can really, where you can feel the pressure when they say 'Oh well I'm gonna go hurt myself' or things like that…

Some participants, again cross all groups, explicitly described these clients as **manipulative**:

> 2.2: …I have an image of them being quite manipulative and attention seeking and you can never quite be sure with the information generally, thinking if it was 100 per cent true, I think you've gotta be quite careful about that when assessing risk, how like if they're saying they took so many tablets, how true actually is

Many participants, across all focus groups, tended to convey an assumption that clients with BPD get 'stuck' and their **ability to change is limited.** Three attributed this to the client's self-defeatism:

> 1.1: …these people always end up in the worst situations, and they often do have a bad starting point but then you just think well this happened and then that and then that and some of those things you can actually see coming and people don't seem to, they seem to have a kind of amazing ability to get into more troubles or……

An image of clients with BPD as **oscillating between extremes**, in terms of several aspects (for example, thinking, emotions and relationships) was conveyed in the accounts of most participants, across all groups:

> 2.1: …she's very, very chaotic and one week, you know, you'll be the best person in the world and then the next week you'll be the worst person in the world, and even within sessions, one minute she can be laughing [laughs] and really happy, and the next minute in lots of tears.

> 2.4: I suppose my first, well idea or exposure to anything like, you know, borderline personality disorder, was em, you know this idea of 'bunny boiler' and you know, [laughs] Michael Douglas and Glenn Close [all laugh] that kind of, you know real quite extreme stuff and this idea of people just being extremely clingy one moment so almost, you know, that if you're thinking about being in therapy with somebody that they want to see you all the time, they could quite happily come back every day, you know, you think about closing off the end of a session, that might be difficult em you know, the other side of that is they just don't want to see you at all…

A further theme conveyed in the narratives of some trainees and qualified staff was clients with BPD being seen as 'over the top' (e.g. exaggerating or over-reacting).

Undesirable Feelings in the Psychologist

A sense of feeling **overwhelmed** by clients with BPD was expressed by several participants, across all groups:

> 3.2: …it's like you feel like you're being thrown in the deep-end when you qualify because all of a sudden there's no selection, you just see everyone and you sometimes get bombarded…

This also included more experienced staff:

> 4.3: Mm, yes if you're getting the whole lot it's really hard isn't it because...it's just you, as the person that's holding this person together...

Several participants across all groups appeared to experience frustration with clients with BPD:

> 1.4: …if I bring sort of exercises or certain things to work through then I'll maybe go through it in the session, but then she'll maybe find that it doesn't work, or she finds that it sounds really difficult to do and you have to adapt it, or you have to just scrap it and do something else, and quite often she'll say 'Well I've tried that and it doesn't work what else is there? Is there nothing else you can do to help?' You know, 'I can't do this, I can't do that, so what else is there, there's nothing for me', you know, those sorts of remarks…

The sub-theme **'anxiety'** was represented in the narratives of many participants, across all focus groups. For some participants, this was in relation to being faced with the prospect of working with these clients without 'feeling equipped'. For several participants, their anxiety conveyed a sense of danger:

> 3.1: I remember distinctly having conversations with [removed] in supervision, and the secretary, about where I should see him, what room I should see him in, and he had no history of any violence, there was no indication, yet I felt so unsafe with him and… I mean I remember we were, for his very final appointment putting me in the room so I was right through the wall so that I would be safe and yet I never knew what I was unsafe from, but there was this feeling and it was quite a strong feeling but I don't know, you know it just doesn't make sense, why would I feel like that, but it was quite nerve-wracking…

The sub-theme **'low self-efficacy'** (Bandura, 1977), whereby participants' belief in their ability to deal with clients with BPD successfully was low, emerged in the narratives of all participants. Some participants spoke about feeling helpless, or powerless, when working with this client group:

> 2.4: …there was still this stuckness there, that you couldn't quite move on, even though yes, uh huh, that seems perfectly reasonable, it was just, you know, moving it on and the next day meeting and it would be something completely different, so it was…… You almost felt fire-fighting and you just felt completely powerless to do anything and this person was clearly saying 'help me', but not, you know, not feeling able to help that person…

A sub-theme which was represented in several narratives, but notably only those of fully qualified psychologists, was that of the psychologist also **oscillating between extremes** when working with clients with BPD:

> 3.2: …it was like one minute I'd go 'Wow yeah he's making progress, yeah!' and the next 'Oh my goodness, I'm incompetent and he's letting me know that', it was the kind of, the extremes of emotions you feel.

Further themes conveyed across the narratives of participants in all groups included a sense of confusion and complexity in their work with clients with BPD, and a pressure to do something to help such clients.

Positive Perceptions of the Client

The sub-theme of **'possibility of change'** (whereby participants conveyed a sense of hope that clients with BPD can change) emerged in several trainee narratives, and in further detail in most of the fully qualified CPs' narratives, who drew on examples of their own cases:

> 3.1: …so we actually, you know, had a sociable ending that happened amicably, where there wasn't a big fall out, which is what I expected he was gonna have to do to be able to deal with leaving but we ended with shaking hands and him saying 'Thank you very much you've been really helpful'…

Three of the qualified CPs portrayed clients with BPD as being **likeable** individuals:

> 4.1: …well I really liked her despite…… And then the other person, I definitely think back on her fondly…it actually ended because I was going on maternity leave…and she got me this lovely picture of a mother elephant and a baby elephant so you know, there were lots of good moments as well…cos often people are very likeable and have got all the positive qualities…

Desirable Feelings in the Psychologist

Empathy towards clients with BPD was evident in the narratives of participants in all groups. For trainees, this appeared to arise from the process of discussing the client group within the focus groups. For qualified CPs, it appeared to be in relation to their own experiences with clients with BPD:

> 4.2: …I think you can't help but have a human reaction to their distress, even though you've kind of got your professional head on…

Interest in clients with BPD was conveyed by 11 participants, throughout all focus groups. For trainees, this was an interest in the client group in general.

> 2.1: …I think it would be kind of exciting and really interesting…yeah I think it would be really interesting and you'd probably find yourself getting hooked in…

Whereas for qualified psychologists, the interest was often conveyed with reference to their own particular clients:

> 4.1: You do wonder how they're doing.
> 4.3: Yes, that's right! [laughs]

Some of the qualified CPs portrayed working with clients with BPD as providing a sense of **reward**. This is illustrated in the following example of Participant 3.1 continuing her narrative about her client having a successful ending to therapy:

> 3.1: …I was quite pleased about that, which I think actually the very ending and the fact that he'd coped with that helped my fears about stalking because I thought actually he impressed me that he was able to do that…

Awareness of Negativity

Most participants, across all groups, conveyed an **awareness of negative perceptions** of clients with BPD. This sub-theme emerged in the processes as well in the content of the discussions. For example, note how Participant 1.4 corrects herself for using the term 'manipulating' in relation to her client with BPD:

> 1.4: …it was just another way of her sort of manipulating, well not manipulating, but her sort of running, controlling the session…

Most interestingly, there appeared to be a tendency for group silences to occur directly following negative themes emerging in the groups, suggesting the participants may have been aware of the 'unacceptability' of negative perceptions:

> 1.4: …she knows, you know, the sorts of things to say to health professionals that mean they won't be able to sort of let her go, em where, you know, with no actual suicidal intent there, em…… So that can be quite hard.
> 1.5: Yeah it's tricky.
> [silence]

Several participants, across all groups, also appeared to be **exploring why** there are such negative perceptions. One participant portrayed a sense of staff projecting their own feelings onto clients:

> 1.2: …you go away having not got through what you wanted to, and just feel quite sort of powerless and [pause] yeah just like you should be able to control things a bit better, that's why you're there and…… I guess that's why people use words like manipulative because, it's because <u>they</u> feel <u>powerless</u> maybe?

A further theme conveyed by several participants, across all groups, was an **awareness of avoidance being unhelpful** (in working with this client group).

<u>Trying to Make Sense of the Chaos</u>

This term, which was used by Participant 1.1, most aptly encapsulated the cluster of sub-themes which follow. These are a range of processes that the CPs engaged in to bring some clarity or understanding to the presenting problems of clients with BPD.

All participants conveyed a sense of **searching for explanations** for BPD. Many formulated, or pondered, over possible factors that might explain the presenting difficulties in these clients. For some this was in relation to clients in general, for others, this was in relation to particular cases:

> 3.2: …she self-harms a lot as well, but I think she directs it at herself because she feels she can't actually let it out at the person she's angry with…

Some participants specifically spoke about how formulation can used as a way of helping to explain BPD:

> 2.4: I suppose that's where things like… a formulation of all the different factors, that's where that kind of thing with these <u>really</u> complex cases, where that could be very, very useful…

Several participants across all groups spoke about the usefulness of **providing structure, or boundaries**, within the therapeutic relationship:

> 1.4: …the more I've seen her, and the more I sort of stick to, you know, <u>boundaries</u> and she's aware of what the boundaries are, then the more comfortable she's actually becoming.

In contrast to the 'different, odd' sub-theme, within the **'normalisation'** sub-theme, many participants, across all groups, also drew on similarities between clients with BPD and other clients, as well as the general population. Some attempted to explain the function of behaviours in BPD by implying that anyone would behave in such a way in similar circumstances:

> 1.1: …I mean what kind of control over things I know that this guy had, he lived in a very restrictive environment, he was on a section, you know, what

> do you do, you try to get control over certain things with, you know, manipulating what else is going on around you…

Further themes conveyed by most participants included the importance of **working on engagement** and building up a trusting relationship. Several participants across all groups also highlighted the possibility of **working on different levels** with clients with BPD, ranging from working with symptoms 'on the surface' to working at a 'deeper' level, with 'timing' being suggested as an important factor in deciding which level to work on.

Working in Contrast to the System

This superordinate theme refers to a sense of CPs working in contrast to other services within the NHS and the medical model, with regards to clients with BPD.

An emphasis on the **problems with diagnosis** was expressed by all participants. This sub-theme was expressed in rich detail by many participants. For some the problems were in relation to the validity of the diagnosis:

> 2.1: …well to me it seems to be like everything that's left over clumped in kind of…… [laughs]

Some also emphasised the negative consequences of the diagnosis:

> 4.2: …if people are diagnosed then sometimes they can be denied services, if they've got personality disorders then, you know, we don't treat them, [makes eye contact with 4.4] as you were saying they do with the forensic team, [4.3: Yeah, that's right] whereas clearly they might have forensic issues.

On the other hand, some participants highlighted the potential benefits of the BPD diagnosis:

> 4.3: One person I had…said 'That is me I know I have this, I'm sure I have'…'It's a relief to find somewhere where I fit, somewhere where……', and really delighted with the idea that 'There's somewhere where I can hang this on, there are interest groups there, I can read up about it'…

Further evidence for this sub-theme is that many participants reported having worked with clients who they think met criteria for BPD, but were not diagnosed. This may reflect the diagnosing clinician's similar sensitivity to this issue, and desire not to label someone with a diagnosis that may be hurtful.

Most participants discussed the **limited impact of psychology** on intervention for BPD. Many such limitations were in relation to financial and time constraints of the NHS, whilst some were in relation to different professionals and agencies not having shared goals around BPD treatment:

> 1.1: But I mean the whole health system really is based on [pause] diagnosis, and having, having that label, and we're not necessarily working in that field, you may not end up diagnosing because you're doing formulation, but a lot of where you look, you know people only just want two or three sentences of summary about whether this person's got personality disorder.

Improving Our Role

Most participants, particularly trainees, expressed a **desire to learn more** about BPD:

> 1.5: …we should all lobby for more teaching [1.3: Yeah] [1.3/1.4: laugh] on personality disorders.
> 1.2: Yeah.
> 1.1/1.3/1.4: [nod]

Some appeared to develop a desire to learn more as a result of the discussion itself:

2.1: It makes me want to go away and read about it [laughs]
2.2/2.4: [nod]
2.3: I was just gonna say that!

Across all groups, participants indicated the **value of experience** in working with clients with BPD. Newly qualified staff implied that since qualifying they had encountered a steep learning curve through their experience in working with this client group:

3.2: …I felt like I was colluding with him from the start, because I just had so little understanding of personality disorder in general, and there was so little teaching on it and there's so little experience that I just went [laughs] straight in there and did exactly what I did with everyone else. [laughs]
3.1: Yeah, me too, my biggest regret, I regret most since I qualified the things I've done in a sort of similar situation where I kind of, I went in doing exactly what I do with everyone else I meet and for that very person it was really problematic and led to lots of stress and anguish.
3.2: Mm.
3.3: Sounds like it was probably quite an important learning experience, when you totally cock it up! [laughs]

CPs at later stages in their careers appeared to look back on earlier experiences with clients with BPD with the benefit of hindsight, through having now had more experience with the client group:

4.2: …I guess being kind of new off the course, I don't think I'd really seen anyone when I was a trainee with that kind of level of problem and kind of looking back, just from people I've seen, kind of makes me think…well she probably had a borderline personality disorder…and I just felt completely unprepared for that…and it was difficult for me to, to work with her because, I think, of my anxiety about her, at that time.

Several participants highlighted the **potential of psychology** to make a positive impact in the area of BPD. For some, clinical psychology was seen as being able to make an impact by not restricting its role to purely individual client work:

> 2.1: There's possibly a quite good opportunity there to liaise with psychiatry more, and do joint working and things like that more…and that would help in turn with things like consultancy and training with people who are involved more on a day to day basis with people with personality disorders, so I suppose it's kind of, there's an opportunity and an opening there I think…

A further theme conveyed by most participants was the **value of support** when working with this client group, through good supervision and supportive team settings.

Discussion

Implications

'Negative perceptions of the client' and 'undesirable feelings in the psychologist' are superordinate themes that have also been reported by previous literature, in other professions (e.g. Markham & Trower, 2003), and with CPs (Brody & Farber, 1996; Servais & Saunders, 2007). CPs appear no less prone to holding negative perspectives of this client group.

What is important in the current study is that these CPs were aware of their negative appraisals and they took active steps to manage them, and continued to commit to providing stable therapeutic relationships with their clients. Participants in this study recognised the challenges inherent in this work and continued to make efforts to value their clients. One key way the CPs report that they do this is by attempting to

understand the processes involved in their clients' presentations and their own reactions to these. Experience of working in this way and professional support also appeared to be factors that helped mitigate the challenges of working with this client group. The design of the current study may have allowed such positive findings to emerge more readily, perhaps through the open-ended nature of the interview, and possibly through the influence of social desirability in a group setting (see limitations).

This study is concerned with the direct experience that CPs have of working with clients with BPD in terms of beliefs, attitudes, thoughts, feelings, motivations and behaviours. Interestingly, these elements of therapist experience have been described from within the psychodynamic psychotherapy literature, primarily in the form of case studies and conceptual papers (e.g. Hodis, 1986; Kernberg & Michels, 2009). These papers tend to share the attribution of such experiences to the concept of countertransference; feelings evoked in the therapist due to the dynamics of the relationship that may be used by a skilled therapist as part of the treatment process. From a psychodynamic perspective, the narratives described in this paper could reflect such countertransferential material. As the current study adopts an phenomenological perspective however, this paper describes the experiences of participants with as transparent and grounded interpretation as possible An important contribution from this paper therefore is that these CPs' experiences of working with clients with BPD are described as they are experienced and understood by the participants themselves.

Experiences and Perceptions at Different Career Stages

The findings of the current study imply that there may be some differences in experiences and perceptions of clients with BPD between CPs at different stages in their careers. Firstly, trainee CPs appeared to have a lack of experience in working with clients with BPD, and claimed there was a lack of teaching in the area. However, all fully qualified staff in the study had experience of working with these clients, suggesting that CPs have a lack of training in a client group they are likely to be working with from the early stages of their careers. Indeed, a 'desire to learn more' was particularly evident in the transcripts of trainees, suggesting that it is at the early stages in their careers that CPs may appreciate gaining knowledge in this area.

Although negative perceptions and undesirable feelings in relation to clients with BPD were expressed regardless of the stage in their careers, in contrast to the findings of Markham (2003) and Brody & Farber (1996), who reported no improvements in perceptions or feelings in relation to these clients in staff at later stages in their careers, 'positive perceptions of the client' and 'desirable feelings in the psychologist' were more fully represented in the narratives of fully qualified staff. Methodological differences from both of these studies may account for the different findings.

It is possible that the differences in the emergence of themes between trainees and fully qualified CPs were due to differences in levels of experience with clients with BPD. However, it may also have been due to other factors that may be different at later stages in careers, such as more knowledge, more opportunities to engage in longer-term therapies, or, as emphasised by Brody & Farber (1996), more awareness of their own feelings.

Limitations

The individual orientation to the analysis allowed the personal experience of the individuals to be explored in line with the IPA perspective, while utilising group factors in the data to enrich the evidence for the emergent themes. In this way, the researcher took advantage of valuable data on group dynamics that would not have been accessible in an individual interview. However, Krueger (1994) warns that focus groups with existing work colleagues can result in extremely complex communication, and that it is impossible for the researcher to determine all the factors that influence group comments. For example, participants may be selective in what they say due to the presence of others in the group (Krueger, 1994).

It should also be noted that the present findings are limited to the fairly homogeneous participants in the study. The sample did not comprise of any male participants, CPs from different settings (e.g. forensic or learning disabilities services) or perhaps most notably, CPs who are 'experts' in the field of BPD, who may have conveyed different themes to those in the present study. It is important to be cautious when considering recommendations for clinical practice. Therefore, the recommendations which follow are largely aimed at the local area of practice.

Recommendations

Clinical Practice

The focus groups not only conveyed a sense of a need to improve the role of clinical psychology, but also generated ideas of how to do this. For example, ideas regarding systemic working, with carers and other professionals, such as joint working, were suggested within the groups. Local multi-professional support networks or special interest groups could help to facilitate such sharing and joint working.

Participants expressed a desire to learn more, and certainly improving knowledge of current theories on BPD is likely to help reduce stigma and improve care (Nehls, 1998). It is recommended that more opportunities for continuous professional development in the area of BPD, are provided and promoted to CPs and other professionals.

Furthermore, given the challenges of working with this client group, it would appear that ongoing supervision is essential, particularly for newly qualified CPs and those with less experience. Such supervision may help to prevent any potential negative feelings and perceptions from compromising the value and stability of therapeutic relationships.

In light of the 'desire to learn more' expressed particularly by trainees, it is urged that the BPS recommendations (Alwin *et al.,* 2006), that more theoretical and practical teaching on assessment and intervention for PD, is provided on Clinical Psychology

Training Programmes. Programmes might also consider ways in which further opportunities for practical experience with this client group might be usefully created.

Future Research

Future research could investigate what factors lead to positive perceptions and desirable feelings in relation to these clients. For instance, they may be attributable to other themes identified in the present study, such as, 'trying to make sense of the chaos', and/or some other factor, such as experience or knowledge.

Conclusions

The present study has drawn out knowledge about CPs' experiences and perceptions of clients with BPD, which may affect how they work with this client group. Negative perceptions and undesirable feelings were common. Despite this CPs were aware of the negativity from their own profession. They engaged in a range of processes in 'trying to make sense of the chaos' of these clients' difficulties, and appeared to emphasise a need to improve their role in the area, as well as suggestions on how to do so. Moreover, positive perceptions and desirable feelings were also common. Such findings serve to counterbalance some of the negative views of clients with BPD, suggesting a degree of hope and optimism.

References

Adshead, G. (1998). Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. *British Journal of Psychiatry, 172(1*), 64-69.

Alwin, N., Blackburn, R., Davidson, K., Hilton, M., Logan, C. & Shine, J. (2006). *Understanding personality disorder: A report by the British Psychological Society.* Leicester: Author.

Bateman, A.W. & Fonagy, P. (2000). Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry, 177,* 138-143.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Brody, E.M. & Farber, B.A. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy, 33(3),* 372-380.

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F. & Kernberg, O.F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. American Journal of Psychiatry, 164, 922-928.

Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H. *et al.* (2006). The effectiveness of cognitive behaviour therapy for borderline personality disorder:

Results from the borderline personality disorder study of cognitive therapy (BOSCOT) trial. *Journal of Personality Disorders, 20(5),* 450-465.

Fallon, P. (2003). Travelling through the system: The lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Nursing, 10,* 393-400.

Fraser, K. & Gallop, R. (1993). Nurse's confirming/disconfirming responses to patients diagnosed with borderline personality disorder. *Archives of Psychiatric Nursing, 7(6),* 336-341.

Gallop, R., Lancee, W.J. & Garfinkel, P. (1989). How nursing staff respond to the label 'borderline personality disorder'. *Hospital & Community Psychiatry, 40(8),* 815-819.

Gisen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C. & van Asselt, T. (2006). Outpatient psychotherapy for borderline personality disorder: Randomised trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry, 63(6),* 649-658.

Hodis, L. (1986). The borderline patient: Theoretical and treatment considerations from a developmental approach. *Clinical Social Work Journal, 14(1),* 66-78.

Kernberg, O.F. & Michels, R. (2009). Borderline Personality Disorder. *American Journal of Psychiatry, 166(5),* 505-508.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal, 311,* 299-302.

Krueger, R.A. (1994). *focus groups: A practical guide for applied research* (2nd edn). Thousand Oaks, CA: Sage.

Lewis, G. & Appleby, L. (1988). Personality disorder: The patients psychiatrists dislike. *British Journal of Psychiatry, 153,* 44-49.

Linehan, M.M., Heard, H.L. & Armstrong, H.E. (1993). Naturalistic follow-up of a behavioural treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50,* 971-974.

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health, 12(6),* 595-612.

Markham, D. & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology, 42,* 243-256.

Nehls, N. (1998). Borderline personality disorder: Gender stereotypes, stigma, and limited system of care. *Issues in Mental Health Nursing, 19,* 97-112.

Nehls, N. (2000). Being a case manager for persons with borderline personality disorder: Perspectives of community mental health centre clinicians. *Archives of Psychiatric Nursing, 14(1),* 12-18.

Sable, P. (1997). Attachment, detachment and borderline personality disorder. *Psychotherapy, 34,* 171-181.

Servais, L.M. & Saunders, S.M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice, 38(2),* 214-219.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using Interpretative Phenomenological Analysis in health psychology. *Psychology and Health, 11*, 261-271.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp.51-80). London: Sage.

Walter, G., Clery, M. & Siegfried, N. (2003). Borderline personality disorder in the public sector: The experience, knowledge and attitudes of mental health staff. *Australian and New Zealand Journal of Psychiatry, 37(1),* A9-A9.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15,* 215-228.

Appendix I

Interview Schedule

- Think back and tell us what experience you have had with clients with borderline personality disorder?

- Think back and tell us about a situation that you have experienced as a clinical psychologist with a client with borderline personality disorder – one that really stands out in your mind?

- Tell us what clients with borderline personality disorder are like?

- Think back and tell us how working with clients with borderline personality disorder makes you feel?

- Tell us about your role in the area of borderline personality disorder?

- Tell us about the main issues involved with dealing with clients with borderline personality disorder?

- Tell us what you think the most important issue in this discussion has been?

- Has anything been missed from the discussion?

Appendix II

Transcription key

Underlining of word (_____): word emphasised by the participants

Six ellipsis (……): speaker trailed off

Three ellipsis (…): denote missing text (where the researcher deemed such text to be less relevant)

Square brackets ([ ]): enclose the researcher's comments, including features of the interaction

[Removed]: denotes text that has been removed to protect the anonymity of the participants